Towards the National Health Assembly II

Booklet 1

Globalisation & Health

National Coordination Committee,
Jan Swasthya Abhiyan

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GLOBALISATION AND HEALTH

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- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- Association for India's Development (AID India)
- Bharat Gyan Vigyan Samiti (BGVS)
- Breastfeeding Promotion Network of India (BPNI)
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- National Federation of Indian Women (NFIW)
- National Association of Women's Organizations (NAWO)
- Ramakrishna Mission (RK)
- Voluntary Health Association of India (VHAI)

Participating Organisations

Over 1000 organisations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Abhiyan campaign as participating organisations.

About the Jan Swasthya Abhiyan

In 1978 at Alma Ata, the governments of the world came together to sign the Alma Ata Declaration that promised "Health for All by 2000". However this promise was never taken very seriously and was subsequently marginalised in health policy discussions.

As the year 2000 approached it appeared that "Health for All by 2000" was quietly being forgotten by governments around the world. To remind people of this forgotten commitment the First People's Health Assembly was organised in Savar, Bangladesh in December 2000 . The People's Health Assembly was a coming together of people's movements and other non-government civil society organisations all over the world to reiterate the pledge for Health for All and to make governments take this promise seriously. The assembly also aimed to build global solidarity, and to bring together people's movements and organisations working to advance the people's health in the context of policies of globalisation.

The national networks and organisations that had come together to organize the National Health Assembly, decided to continue and develop this movement in the form of the Jan Swasthya Abhiyan (People's Health Movement). Jan Swasthya Abhiyan forms the Indian regional circle of the global People's Health Movement..

Despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people worldwide. Enduring poverty with all its facets and in addition, resurgence of communicable diseases including the HIV/AIDS epidemic, and weakening of public health systems is leading to reversal of previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under threat.

These trends are to a large extent the result of the inequitable structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, unfair world trade arrangements and uncontrolled financial speculation - all part of the rapid movement towards inequitable globalisation. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Within the health sector, failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis. These deficiencies include:

- A retreat from the goal of comprehensive national health and drug polices as part of overall social policy.
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society.

- A failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread and usually inequitable policies of privatisation of health services.
- A narrow, top-down, technology-oriented view of health and increasingly viewing health care as a commodity rather than as a human right.
- It is with this perspective that the organisations constituting the Jan Swasthya Abhiyan have come together to launch a movement, emerging from the Peoples Health Assembly process. Some objectives that this coalition set for itself (which are set out in detail in the Peoples Health Charter) can be listed briefly as below:
- The Jan Swasthya Abhiyan aims to draw public attention to the adverse impact of the policies of iniquitous globalisation on the health of Indian people, especially on the health of the poor.
- The Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 A.D.' pledge. This historic commitment needs to be renewed and taken forward, with the slogan 'Health for All - Now!' and in the form of the campaign to establish the Right to Health and Health Care as basic human rights. Health and equitable development need to be reestablished as priorities in local, national, international policy-making, with Primary Health Care as a major strategy for achieving these priorities.
- In India, globalisation's thrust for privatisation and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialise medical care. Irrational, unethical and exploitative medical practices are flourishing and growing. The Jan Swasthya Abhiyan expresses the need to confront such commercialisation, while establishing minimum standards and rational treatment guidelines for health care.
- In the Indian context, top down, bureaucratic, fragmented techno-centric approaches to health care have created considerable wastage of scarce resources and have failed to deliver significant health improvements. The Jan Swasthya Abhiyan seeks to emphasize the urgent need to promote decentralisation of health care and build up integrated, comprehensive and participatory approaches to health care that places "Peoples Health in Peoples Hands".

The Jan Swasthya Abhiyan seeks to network with all those interested in promoting peoples' health. It seeks to unleash a wide variety of people's initiatives that would help the poor and the marginalised to organise and access better health care, while contributing to building long-term and sustainable solutions to health problems

The Jan Swasthya Abhiyan is being coordinated by National Coordination Committee consisting of 21 major all India networks of peoples movements and NGOs. This is the third book in a six booklet series brought out by the NCC for the NHA II.

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Introduction

Balancesheet of Globalisation

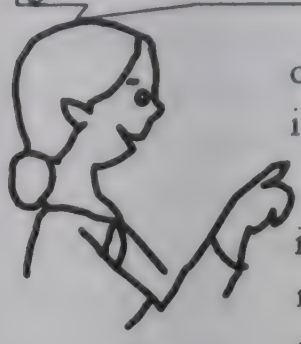
Social and economic inequalities translate into nutritional and health inequalities. Despite remarkable achievements in global health over the last four decades, there is a 16-fold difference in infant mortality between the 26 wealthiest nations and the 48 least developed countries. Of the world's 6 billion people, an estimated 3 billion survive on the equivalent of less than $2 a day; 1.3 billion of them on less than 1 $ a day. Every day 840 million people go to bed hungry. Half of the people in the world's poorest 46 nations are without access to modern health car; three billion people - half the world's population - do not have access to sanitation facilities; one billion do not have access to safe drinking water.

Of the 100 largest economies in the world, 51 are multi-national corporations and only 49 are countries. The ratio between the wealthiest and the poorest countries in terms of per capita income has grown from 11 to 1 in 1870, to 38 to 1 in 1960, to 52 to 1 in 1985. In 1988, the average income of the world's wealthiest 5 per cent of people was 78 times that of the world's poorest 5 per cent; just five years later, this ratio had increased to 123 to 1. The gap continues to widen.

Is this what globalisation is about? Or is it about the imposition of certain patterns of development over the whole globe that benefits a small section of the global population while depriving the vast majority?

The per capita income in 100 countries is now lower than it was 20 or 30 years back. In Africa, the average household consumes 20 per cent less today than it did 25 years ago. 1 billion people saw their real incomes fall between 1980 and 1993. At the end of the 1990s, the wealth of the three richest individuals on earth was greater than the

Is this why so many people across the world are rising up to protest the current pattern of globalisation?



combined annual GDP of the 48 least developed nations.

Three hours of world-wide military spending is equal to the WHO's annual budget. Three weeks of world arms spending could provide primary health care, including water and sanitation, for all individuals in poor countries.

"Globalisation" is a word that has been increasingly heard over the last three decades. It means many things to many people. To some it means a large variety of goods, increasingly available all over the world. People who can afford to buy such goods argue that globalisation provides people a choice in the market place. A small section of people in India can now have access to the best of products available from abroad - from clothes to cosmetics, from perfumes to Porches, from cars to computers and from banks to insurance. Such people see globalisation as not only inevitable but also as desirable. Usually, of course, these are also the people who have gained from the process of globalisation. There are others who see globalisation as "Westernisation". They object to the loss of "Indian" values and culture, contaminated by ideas from the "West".

How has globalisation affected different countries & who are the winners and losers in globalisation? How does it impact on health.

These are simplistic and often mistaken understandings of globalisation. Globalisation is a complex process that is having profound impact on all people across the world. No one would deny that globalisation is indeed to be welcomed if it means greater exchange of ideas and people across countries. But is that happening?

LET'S SEE! SOME OF THE ISSUES THAT WILL BE ADDRESSED IN THIS BOOKLET

SECTION I

How Did Today's Phase of Globalisation Start?

Human beings, as long as they have lived on earth, have been moving around the world, trading, learning and interacting. But from the seventeenth century arose a new situation, that of colonialism. Colonialism is often referred to as the first wave of globalisation and contributed to the most significant feature of the global economy today: the division between the First World, of, by and large, colonial nations, and the Third World, of colonised ones.

After the Second World War, newly liberated nations like India, China and many others attempted to break free of the colonial chains that had forced their countries into underdevelopment. Policies of self-reliant development were put in place in the newly independent nations of Asia, Africa and Latin America that minimised dependence on the developed nations for import of resources and technology. Food availability and incomes rose in these countries, as did investment

in social sectors such as health, nutrition and education. Reflecting all these changes there were improvements in health indices as life expectations increased, the morbidity and mortality rates declined and birth rates increased.

In the late 1970s, however, the global economy was overwhelmed by a crisis, where growth of production started slowing down and rates of unemployment started growing alongside rises in prices of commodities. These changes took place together with the collapse of the Soviet Union and the state controlled economies of the socialist world. They also led to a reshaping of the capitalist world, and led to a complex of changes known as globalisation, privatisation and liberalisation. They are also described, equally accurately, as corporate globalisation, or imperialist globalisation.

Economic policies that were now imposed by the developed countries, called "neo-liberal" policies, reflected an ideological commitment to market principles, ignoring the remarkable role that the government had played even in the advanced capitalist countries. After the Second World War, government involvement in public health had been considered crucial and essential in developed countries of Europe. Soon neoliberal policies came to be imposed in the developing countries as well, at the insistence of the developed nations and the institutions controlled by them, such as the World Bank and the International Monetary Fund (IMF). Reduction of the role of governments and importance provided to the role of the market was thus at the center of this model of development. Economic growth, it was maintained despite extensive evidence to the contrary, would trickle down to the less fortunate and thus result in overall development.

What Did Globalisation Mean for Poor Countries like India?

We discussed earlier, the developed countries in North America and Europe were engulfed in an economic crisis in the 1970s. But very quickly they found a way out of this. They did this by transferring the major impact of the crisis on to developing countries like India.

One method they did this was by opening up the markets of these countries by dangling the promise that a "borderless world" under globalisation will benefit everybody. The rich countries and the large banks that they controlled had already used the bait of easy loans to trap many developing countries into a debt crisis.

My country is under huge indebtedness! Why should I worry so much about returning merely Rs. 500 to the Seth!

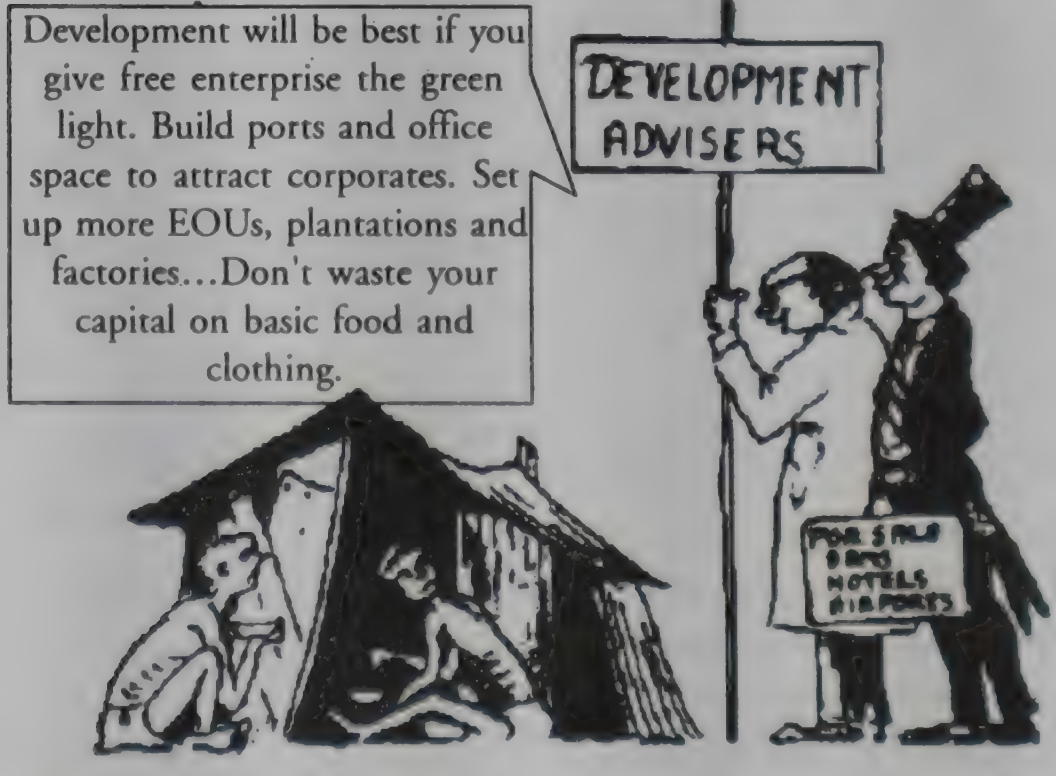
The debt crisis meant that many poor countries could not even pay back the interests on the loans they had borrowed. Now the developed countries used this situation to their advantage. They said that they would bail out these countries facing a debt crisis by giving even more loans! But now these loans would be tied to certain conditions. Future loans were now linked to accepting a broad package of policies called Structural Adjustment Programme (SAP). These policies, that were now forced upon poor debt ridden countries, included conditions that governments need to spend much less on social sectors like food security, health and education. The conditions also required these countries to open their markets to goods and services from the rich countries. In agriculture these countries were asked to produce for exports and not worry about producing food grains for their own people.

The rich countries took advantage of our debt crisis and placed conditions on future loans, they sought to offer. They wanted us to open our markets to goods and services of developed countries, and produce food grains for exports without fulfilling our domestic needs.

These policies were implemented in Latin America and Africa in the 1980s. In the agricultural sector, this led to the reinforcement of colonial patterns of agricultural production, stimulating the growth of export-oriented crops at the cost of food crops. The problem at the heart of this pattern of production is that it was implemented at a time when the prices of primary commodities (that is, products from agriculture and mining) were the lowest in history. By 1989, prices for agricultural products were only 60 per cent of their 1970 levels. This led to the further devastation of the economies of these countries and seriously affected food availability.

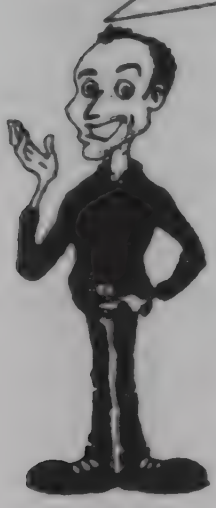
In the industrial sector, the new policies forced governments in developing countries to withdraw support to their own industries. The government run public sector, set up to create basic infrastructure and provide public utilities like electricity, roads, communications, water, etc. were systematically dismantled. They were privatised, or handed over to multinational corporations.

Further, over this period, capital (money) across the globe was concentrated in fewer and fewer hands. The driving force behind this phase of imperialist globalisation became this accumulated money. Countries were forced to remove restrictions on the flows of this


Development will be best if you give free enterprise the green light. Build ports and office space to attract corporates. Set up more EOUs, plantations and factories...Don't waste your capital on basic food and clothing.
DEVELOPMENT ADVISERS

capital in and out of their countries. This money is called speculative capital because it is invested for short term profits - just like a gambler would do - without any intention to create facilities that would promote manufacturing capabilities. Thus economies of poor countries are captive in the hands of those who have huge amounts of money - large multinational banks based in rich countries or foreign institutional investors (FIIs) - who have the ability to shut down these economies in matter of days if they decide to move their money to some other country.

In spite of all the talk about developing countries receiving aid from the rich countries, in actual practice, every year close to 80 billion USD are paid by the former to latter just in order to return the loan that were forced upon them earlier.



Together these policies and processes increased indebtedness of Third World countries that they were supposed to reduce, increased the rate of exploitation of wageworkers across the globe, and shifted wealth from productive to speculative sectors. The policies also led to the increase of casual, poorly paid and insecure forms of employment. Fund cuts in education and health also meant that already weak and under-funded systems of health, education and food security collapsed. It is thus not accidental that these policies increased levels of poverty in already poor countries even as a small section of the population became richer; this section of the middle and upper classes obtained access to consumer goods that were earlier available only in the rich countries.

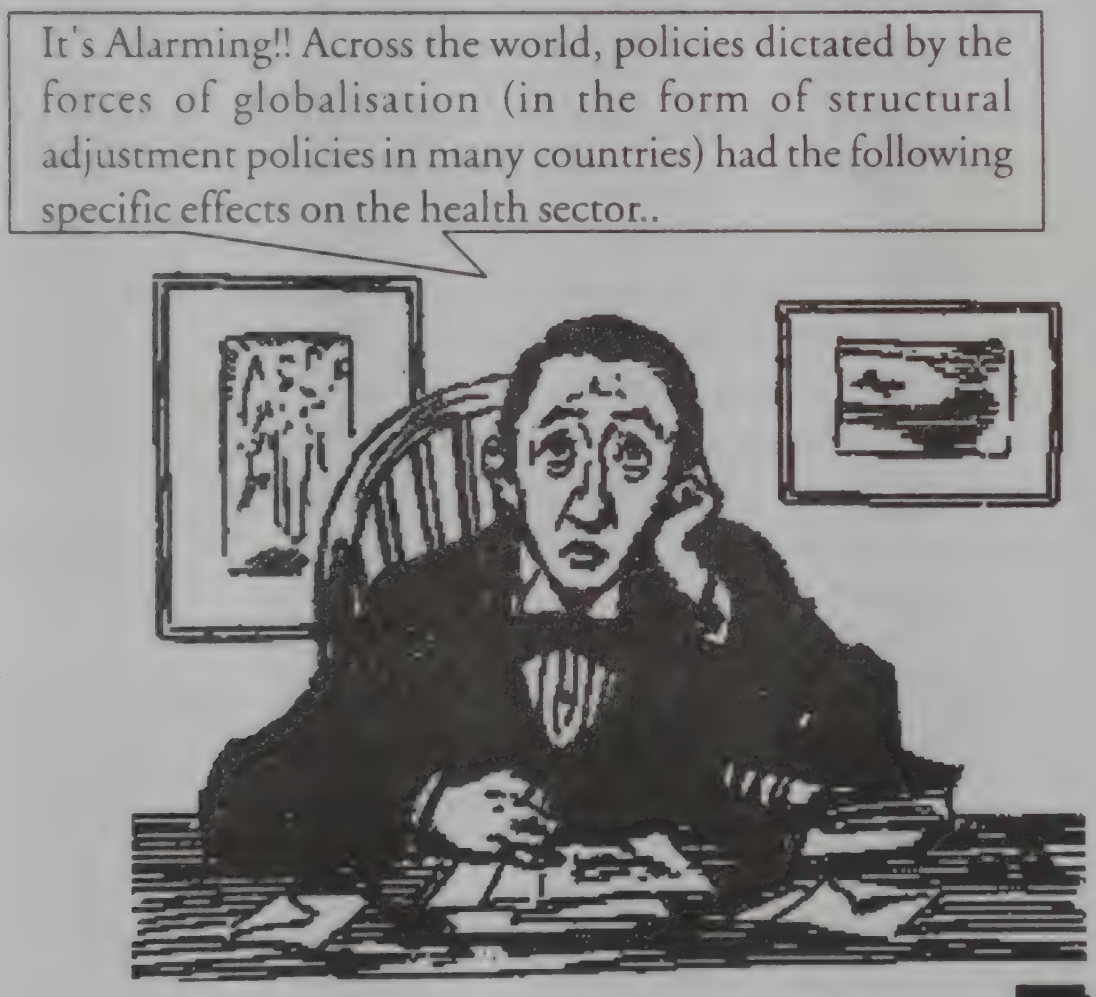
Indeed this figure has increased substantially over the last three decades. Between 1990 and 1993 sub-Saharan Africa alone transferred 13.4 billion dollars annually to its creditors, substantially more than it spent on education and health combined. From 1987 to 1993, the net transfer of resources from Africa to the IMF was 38 billion dollars. As a result, inequalities within and between countries have

risen sharply: the income gap between the world's richest and poorest has more than doubled, although the world has never been as rich as it is today. In 1960 the 20 per cent of the world's people in the richest countries had 30 times the income of the poorest 20 per cent; today they command 74 times more. The same richest 20 per cent of the population command 86 per cent of the world GDP while the poorest 20 per cent command merely 1 per cent. More than 80 countries have per capita incomes lower than they were a decade or more ago; 55 countries, mostly in sub-Saharan Africa, Eastern Europe and the former Soviet Union, have had declining per capita incomes.

SECTION II

How has Globalisation Affected Health in Different Countries?

Public health is an obvious casualty of this process. There is a clear contradiction between the principals of public health and neo-liberal economic theory. Public health is a "public good", i.e. its benefits cannot be individually enjoyed or computed, but have to be seen in the context of benefits that are enjoyed by the public. Thus public health outcomes are shared, and their accumulation lead to better living conditions. It does not mechanically translate into visible economic determinants, viz. income levels or rates of economic growth. Kerala, for example, has one of the lowest per capita incomes in the India but its public health indicators that approach the levels in many developed countries. The Infant Mortality Rate in Kerala is less


It's Alarming!! Across the world, policies dictated by the forces of globalisation (in the form of structural adjustment policies in many countries) had the following specific effects on the health sector..

than a third of any other large state in the country. But neo-liberal economic policies do not even acknowledge such benefits. The current economic policies would rather view health as a private good that is accessed through the market.

i. A cut in the welfare investment, leading to gradual dismantling of the public health services.

ii. Introduction of service charges in public institutions, making the services inaccessible to the poor.

iii. Handing over the responsibility of health service to the private sector and undermining the rationality of public health. The private sector on the other hand focused only on curative care. India for instance, was forced to reduce its public health expenditure in health and to recover the cost of health services from its users by international banks.

iv. The voluntary sector, which has also stepped in to provide health services is forced to concentrate and prioritize only those areas where international aid is made available - like AIDS, population control, etc.

These "fundamentals" were more sharply focused upon in 1987 by the World Bank document titled "Financing Health Services in Developing countries" which made the following recommendations for developing countries.

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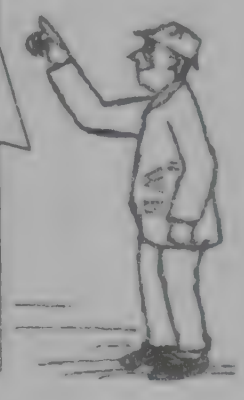


1) Increase amounts paid by patients.
2) Develop private health insurance mechanisms (this requires a dismantling of state supported health services as if free or low cost health care is available there is little interest in private insurance).
3) Expand the participation of the private sector.

4) Decentralise government health care services (not real decentralisation but an euphemism for "rolling back" of state responsibility and passing on the burden to local communities).

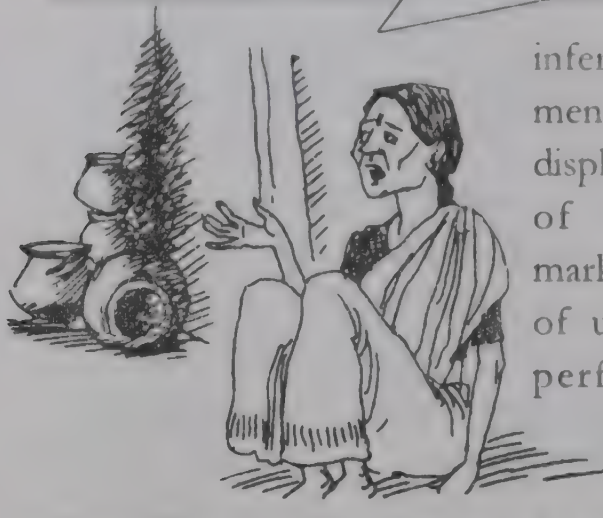
These recommendations were further "fine tuned" and reiterated by the Bank's World Development Report, 1993 titled "Investing in Health". Today the Bank is the decisive voice in this regard, and the organisations like WHO and UNICEF have been reduced to playing the role of "drum beaters" of the Bank.

In almost every developing country, where these prescriptions have been followed, public health conditions have deteriorated. In Philippines health expenditure fell from 3.45% of GDP in 1985 to 2% in 1993; and in Mexico from 4.7% of GDP to 2.7% in the decade of the 80s. Even developing countries with a strong tradition of providing comprehensive welfare benefits to its people were not spared (with the exception of Cuba). In China health expenditure is reported to have fallen to 1% of GDP and 1.5 million TB cases are believed to have been left untreated since the country introduced mechanisms for cost recovery. In Vietnam the number of villages with clinics and maternity centers fell from 93.1% to 75%.

The involvement of the WB & IMF in moulding the policies of countries in Latin America, Africa and Asia expanded dramatically in the 1980s: by the end of 1991, 75 countries had implemented structural adjustment policies that had an impact on the health sector.

There have been dramatic reversals of health gains made after the Second World War. Thus the gap in the under-five death rate, considered a sensitive indicator of social and economic development, has widened between the rich countries and the poor. The under-five death rate gap increased from a ratio of 7.8 in 1978 to 12.5 in 1998. Similarly, the death rate ratio in the age group five to fourteen has also increased from 3.8 in 1950 to 7 in 1990. The impact was not

An important consequence of globalisation has been commonly described as the "feminisation of poverty" as women increasingly had to strive to hold families together in various ways in the face of increasing pressures, chief among them are increasing poverty and insecurity.



limited only to poor countries. In a number of the developed industrial countries, inequalities in health outcomes are being soon among the poor.

In many countries, more women entered the labour force but typically at lower wages and with inferior working conditions than for men; in many others, women were displaced from employment as levels of unemployment increased markedly. Simultaneously, the extent of unpaid labour in households, performed largely by women, increased as public provision of basic goods and services declined. Young children, especially girls, were increasingly withdrawn from school to join the vast and grossly underpaid informal labour market or to assist in running the household. Rising food prices, along with cuts in subsidies for the poor, meant that an increasing proportion of families with precarious resources were pushed under the poverty line, affecting women and girl children disproportionately. As the table below indicates, they had to work for longer hours to purchase the same amount of foods as before, thus getting increasingly exploited. This also meant an increase in young women - and indeed women in general - being pushed into the sex industry, now increasingly global.

Given increasing levels of under nutrition, infant and child mortality rates, which had earlier shown a decline, either stagnated or in the case of some countries, actually increased. So widespread were these effects that even the UNICEF issued calls for "a human face" to structural adjustment programme.

Table 1

Hours Worked to Purchase 1,000 Calories Before and After SAPs

	1975	1984
Barley	0.07	0.59
Sugar	0.16	0.51
Corn	0.17	0.64
Wheat flour	0.21	0.52
Dried beans	0.22	3.47
Rice	0.22	0.48
Bread	0.28	0.51
Oil	0.28	0.51
Potatoes	0.76	2.35
Onions	1.02	3.22
Milk	1.05	3.95

Source: Susan George (1990), A Fate Worse Than Debt: The World Financial Crisis and the Poor, PIRG, New Delhi.

In the face of such evidence, even the World Bank was forced to modify its earlier recommendations. The World Bank started talking about investing in the poor through investments in health and education; and about the promotion of safety nets and targeted social programmes. This is a clear recognition that specific programmes are necessary to protect the poor from the consequences of structural adjustment and that economic growth by itself does not reduce the problem of poverty. But these changes in the World Bank's thinking are still too inadequate and have come too late for millions who have died as a result of the policies it had promoted.

Because of these effects the last two decades of the 20th century have often been described as lost decades. In 1960, the poorest 20 per cent of the global population received 2.3 per cent of the global income. By 1991, their share had sunk to 1.4 per cent. Today, the poorest 20 per cent receive only 1.1 per cent of global income. The

ratio of income of the wealthiest 20 per cent of the people to that of the poorest 20 per cent were 30 to 1 in 1960.

By 1995, that ratio stood at 82 to 1. This is based on distribution between rich and poor countries, but when the maldistribution of income within countries is taken into account, the richest 20 per cent of the world's people in 1990 got at least 150 times more than the poorest 20 per cent. The 20 per cent of the world's people who live in the highest income countries account for 86 per cent of the global consumption, the poorest 20 per cent, only 1.3 per cent. In other words, while the world had grown incomparably richer, the wealth generated had been distributed remarkably unequally.

Do Communicable Diseases Spread Faster Under Globalisation?

In addition to the key area of IMF/Bank induced health sector reforms, globalisation impinges on the health sector in many other ways. Globalisation leads to transnationalisation of public health risks.

Studies indicate that due to rising food prices & subsidy cuts, hunger and morbidity levels have increased. Poor people were increasingly unable to access health institutions, which, under the reform measures, typically introduced fee for services; and it is not at all surprising!

A major effect has been the resurgence of communicable diseases across the globe. Every phase of human civilisation that has seen a rapid expansion in exchange of populations across national borders has been characterised by a spread of communicable diseases. The early settlers in America, who came from Europe, carried with them small pox and measles that decimated the indigenous population of Native Americans. Plague traveled to Europe from the orient in the middle ages, often killing more than a quarter of the population of cities in Europe (like the plague epidemic in London in the fifteenth century). This is a natural consequence of exposure to local populations to exotic diseases, to which they have little or no natural immunity.

Due to poor health, nutritional status and poor access to health care in developing countries like ours, we are most susceptible to communicable diseases.

Today what incubates in a tropical rainforest can emerge in a temperate suburb in affluent Europe, and likewise

what festers in a metropolitan ghetto of the global North can emerge in a sleepy village in Asia - within weeks or days.

In the case of AIDS the combination of global mobility and cuts in health facilities has been lethal for many developing countries - the disease in Africa, and now in Asia has ravaged a whole generation. Let us not forget that AIDS first manifest itself in the US, but it was Africa that feels the real force of its wrath. In the 1960s scientists were exulting over the possible conquest to be achieved over communicable diseases. Forty years later a whole new scenario is unfolding. AIDS is its most acute manifestation. We also have resurgence of cholera, yellow fever and malaria in Sub-Saharan Africa, malaria and dengue in South America, multi-drug resistant TB, plague, dengue and malaria in India. We see the emergence of exotic viral diseases, like those caused by the Ebola and the Hanta virus. Globalisation that forces migration of labour across large distances, that has spawned a huge "market" on commercial sex, that has changed the environment and helped produce "freak" microbes, has contributed enormously to the resurgence.

How Does Globalisation Affect the Environment and our Lifestyles?

Globalisation has also set in motion a variety of unsafe and hazardous practices. The present global division of labour has led to the dumping of hazardous wastes and the whole-scale relocation of hazardous industries to developing countries. A World Bank economist, Lawrence Summers, aptly sums up the trend. "I think the economic logic behind dumping a load of toxic waste in the lowest wage country is impeccable... I've always thought that under populated countries in Africa are vastly under polluted; their air quality is vastly inefficiently low compared to Los Angeles or Mexico City"

The consumerist culture that is encouraged by corporate led globalisation has also put the long-term sustainability of the planet in jeopardy. Excessive fossil fuel use has already led to the threat of "global warming". Unregulated use of refrigerants has led to depletion of the protective ozone layer, exposing people to the deadly effects

of the sun's radiation. Alongside this, corporates continue to pillage the biological resources of the globe, leading to the disappearance of a number of species of plants and animals. This has disrupted the ecology of the land and the sea. If the trend continues, the globe as we know it, may cease to exist a hundred years from now.

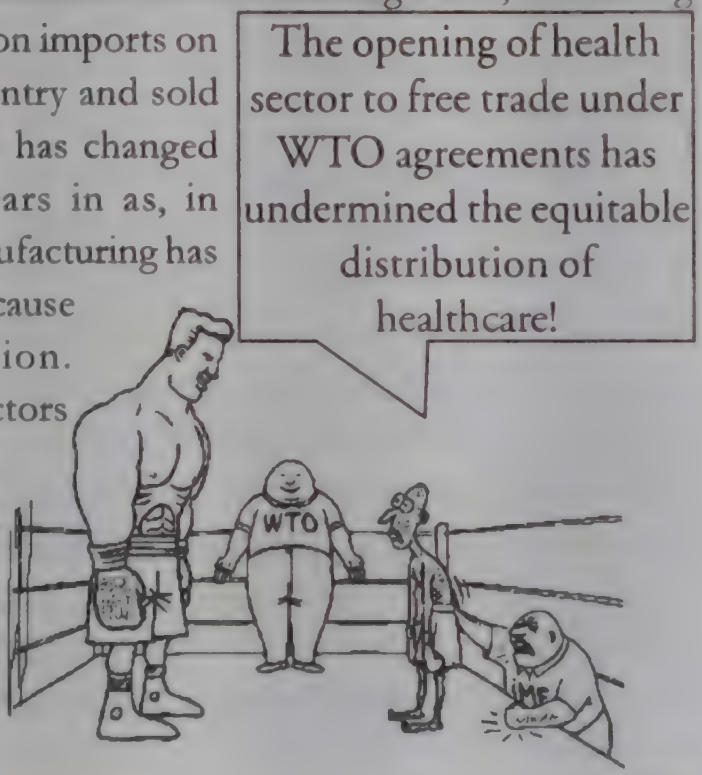
The same consumerist culture has led to unhealthy lifestyles - sedentary habits, preference for unhealthy "junk foods", over-indulgence in addictions like tobacco and alcohol, etc. Globalisation encourages trade in unhealthy products - alcohol, tobacco, and baby foods. Consequently, **people in the third world are suffering from the ill effects of "development" superimposed on the problems of underdevelopment.**

How Does the World Trade Organisation Affect the Health Sector?

Different portions of the World Trade Organisation have an impact on the health sector. Some of the important agreements under the WTO, which have an effect on health, are described below:

The General Agreement on Trade in Services (GATS)

Historically trade agreements involved reducing tariffs, eliminating trade barriers like quotas on imports on goods produced in a country and sold elsewhere. However, this has changed drastically in recent years in as, in developed countries, manufacturing has ceased to be profitable because of global competition. Presently, the services sectors have expanded and are growing at the fastest rates in these countries. The service sectors accounts for two thirds of economy and jobs in


The opening of health sector to free trade under WTO agreements has undermined the equitable distribution of healthcare!
WTO
IMF

the European Union (EU), almost a quarter of the EU's total exports and a half of all foreign investment flowing from the Union to other parts of the world. In the US, more than a third of economic growth over the past five years has been because of service exports.

As the service sectors of the economies of developed countries grew, trade in various types of services was exported. Multinational Corporations started lobbying for new trading rules that will expand their share of the global market in services as governments everywhere spend a considerable amount of their budget on social services.

This is what the General Agreement on Trade in Services (GATS) under the WTO is targetting today. GATS cover some 160 separate sectors. In the WTO meeting in Seattle, the US specifically wanted to focus on free trade in services in the professions, health and education.

The GATS as in all the other agreements contains provisions which allow further deregulation of any national legislation which is seen to be hostile to free trade. GATS identify the specific commitments of member states that indicate on a sector-by-sector basis the extent foreigners' may supply services in the country. The negotiating process in GATS allows for countries to decide, through 'request offer' negotiations, which service sectors they will agree to cover under its rules. This refers to the extent to which member states want their these services like health and education to be opened up to free trade.

Today private insurance companies, managed (health) care firms; health care technology companies and the pharmaceutical industry of the developed countries are looking for opportunities to expand health care markets. In the Third World, much of private health services were by and large provided by non-governmental organisations like charities, religious societies and community oriented associations, which were not entirely profit driven. This will change when health services and investments in health expand and the corporate sector is poised to play a prominent role especially in countries where there is an affluent elite willing to pay or where there exists a private health service base: like in India. This move to open up the health and social sectors

to allow privatisation and competition from the private sector will mean that, the latter will take over health and social services of countries for profit undermining the equitable distribution of healthcare.

Trade Related Intellectual Property Rights (TRIPS) - No Medicines for the Poor

While unleashing new horrors in the form of disease, globalisation has also compromised people's ability to combat them. The WTO agreement on Patents (called the Trade Related Intellectual Property Rights - TRIPS) has sanctified monopoly rent incomes by pharmaceutical MNCs. The WTO defines 'Intellectual Property Rights' as, "the rights given to persons over the creations of their minds. They usually give the creator an exclusive right over the use of his/her creation for a certain period of time." TRIPS protects the interests of big biotechnology, pharmaceutical, computer software and other businesses and imposes the cost of policing on cash-strapped governments, while slowing down or preventing altogether the transfer of useful technology.

The Trade Related Intellectual Property Rights (TRIPS) agreement, signed as a part of the WTO agreement, was the most bitterly fought during the GATT negotiations. Till 1989 countries like India, Brazil, Argentine, Thailand and others had opposed even the inclusion of the issues in TRIPS in the negotiating agenda. They did so based on the sound argument that Intellectual Property Rights - which includes Patents over medicines - is a non-trade issue. India and others had argued that rights provided in domestic laws regarding intellectual property should not be linked with trade. They had further argued that the history of IPRs shows that all countries have evolved their domestic laws in consonance with the stage of economic development and development of S&T capabilities. Laws that provide strong Patent protection limit the ability of developing countries to enhance their S&T capabilities and retard dissemination of knowledge. Japan, for example, was able to enhance its domestic capabilities through the medium of weak patent protection for decades - well into the second half of the twentieth century. Italy changed to a stronger protection regime only in 1978 and Canada as late as in 1992. It was thus natural

that many countries like India had domestic laws that did not favour strong protection to Patents before the WTO agreement was signed. It was illogical to thrust a single patent structure on all countries of the globe, irrespective of their stage of development.

These arguments were however systematically subverted during the GATT negotiations, leading to the signing of the TRIPS agreement. The TRIPS agreement required countries like India to change over to a strong patent protection regime. A regime that would no longer allow countries to continue with domestic laws that enabled domestic companies to manufacture new drugs invented elsewhere, at prices that were anything between one twentieth and one hundredth of global prices. It may be recalled that it was the 1970 Patent Act, which, by encouraging Indian companies to develop new processes for patented drugs, also facilitated the development of world class manufacturing facilities in a developing country like India.

Less than 10% of the $56 billion spent each year globally on medical research is aimed at the health problems affecting 90% of the world's population.

The TRIPS agreement has placed enormous power in the hands of MNCs, by virtue of the monopoly that they have over knowledge. They have generated super profits through the patenting of top selling drugs. But drugs which sell in the market may have little to do with the actual health needs of the global population -- for, often, there is nobody to pay drugs required to treat diseases in the poorest countries. Research and patenting in pharmaceuticals driven, not so much by actual therapeutic needs, but by the need of companies to maintain their super profits at present levels. Simultaneously, new drug development has become more expensive because of more stringent regulatory laws. This is a major reason for the trend towards global mergers, as individual Companies wishing to retain the huge growth rates of the 1970s and 80s, are trying to pool resources for R&D. As a consequence, we are looking to a new situation, where 10 -12 large

Transnational conglomerates will survive as "research based" Companies, that Companies is that will be in the business of drug development and patenting.

Given their monopoly over knowledge, these companies will decide the kind of drugs that will be developed -- drugs that can be sold to people with the money to buy them. Thus on one hand we have the development of "life-style" drugs, i.e. drugs like viagra, which target illusory ailments of the rich. On the other hand we have a large number of "orphan" drugs -- drugs that can cure life-threatening diseases in Asia and Africa, but are not produced because the poor cannot pay for them. Today's medical research is highly skewed in favour of heart diseases and cancer as compared to other diseases like malaria, cholera, dengue fever and AIDS which kill many more people - especially in developing countries. Just 4% of drug research money is devoted to developing new pharmaceuticals specifically for diseases prevalent in the developing countries.

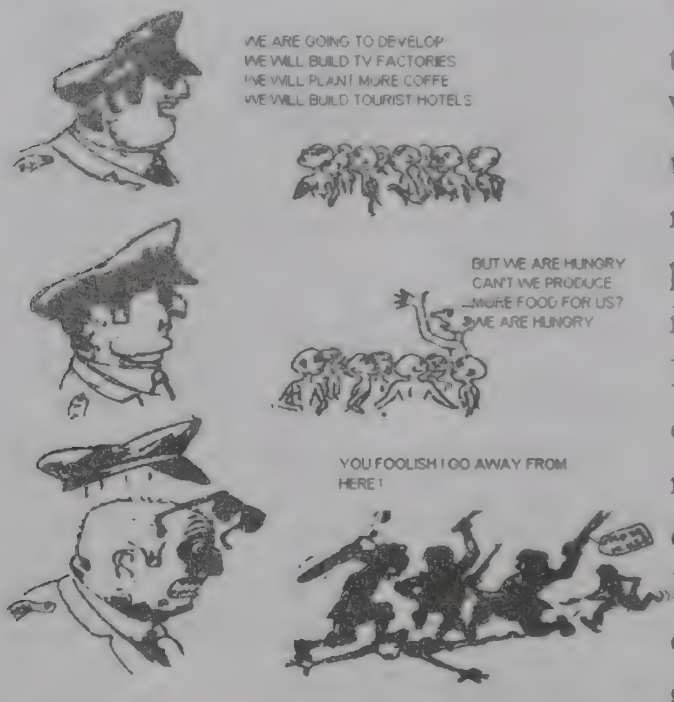
Some drugs developed in the 1950s and 1960s to treat tropical diseases, on the other hand, have begun to disappear from the market because they are seldom or never used in the developed world.

Agreement on Agriculture -- Assault on Food Security

The present phase of globalisation also has grave consequences for food security, which is an integral part of good health. The Agreement on Agriculture (AoA), under WTO has further skewed the balance against developing countries. India is just beginning to feel the rigours of the Agreement on Agriculture that was part of the WTO agreement of 1995. Specifically, the lifting of restrictions on imports, as required by the AoA has resulted in widespread disruption of the rural economy. The suicides by farmers in many

states is a fast unfolding testimony to the grim situation before us.

The AoA ensured that subsidies provided to domestic agriculture by developing countries would be phased out while those being provided by developed countries would be retained. This has resulted in exports of primary commodities by developing countries becoming uncompetitive while their domestic markets are being flooded by subsidized imports from developed countries. This has been compounded by pressures of the SAP induced policies to produce for the export market. As a result vast tracts in India now grow "cash" crops like cotton, tobacco, sunflower, etc. We in India would recall the devastation and violent reactions that were provoked by forced indigo cultivation in Bengal in the nineteenth century. The actors have not changed, only the excuses offered have! Because a few developed countries control the global rules of the game, in the past decades the global prices of agriculture exports from developing countries have fallen steadily. As a result farmers get less and less for their products, while the growth in production of staple food grains has fallen sharply.

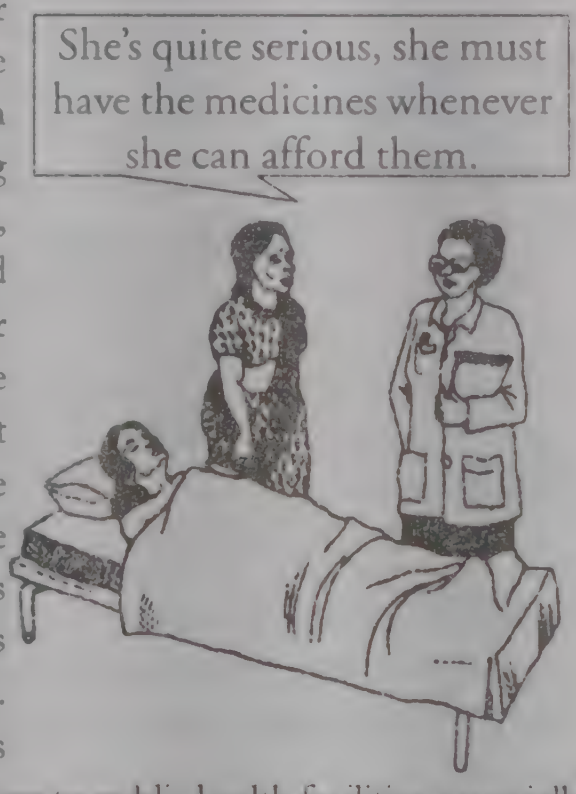

WE ARE GOING TO DEVELOP
WE WILL BUILD TV FACTORIES
WE WILL PLANT MORE COFFE
WE WILL BUILD TOURIST HOTELS
BUT WE ARE HUNGRY
CAN'T WE PRODUCE
MORE FOOD FOR US?
WE ARE HUNGRY
YOU FOOLISH ! GO AWAY FROM
HERE !

Control over global agriculture is sought to be exercised by other means too. MNCs are pushing through a regime that will allow Patenting of seeds. At the same time they are using Biotechnology to research new varieties that are genetically modified. These two measures can allow virtual monopoly to such MNCs over seed production, and consequently total control over agriculture. If allowed, a handful of companies will decide who will grow what and what will be consumed in the globe. The implications are clear!

SECTION III

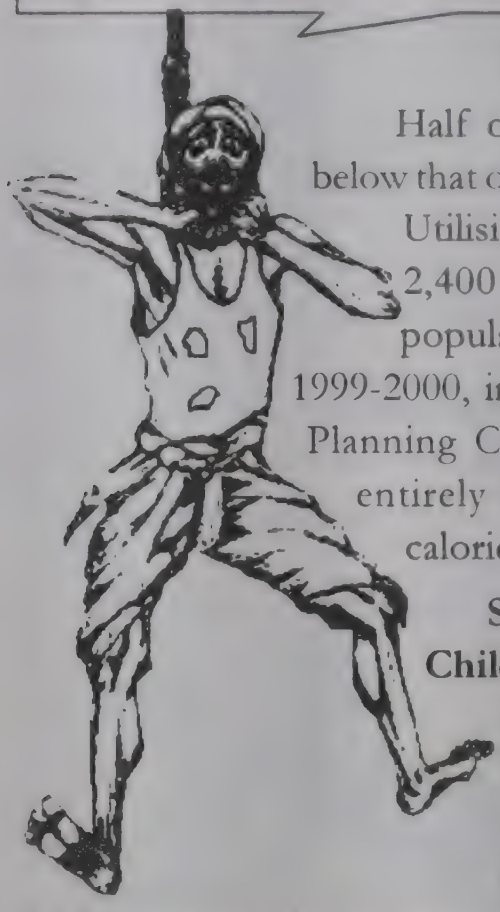
How has Globalisation Affected Health Conditions in India?

The evidence from India is unmistakable, even with all the limitations caused by reliable data not always being available. Over the last fifteen years, since India's economic liberalisation programme started in 1991, there has been a sharp decline in the government's commitment to public health. Thus today our country has the fifth lowest public health expenditure in the world. As the National Health Policy admitted, this is, at 0.9 per cent of the GDP; lower than the average in even Sub Saharan Africa. Along with decreasing government spending on health, policy measures have encouraged the growth of the private sector in health care so that today we have the largest, and least regulated, private health care industry in the world. Evidence from across the country indicates that access to health care has declined sharply over this period. The policy of levying of user fees has impacted negatively upon access to public health facilities, especially for poor and marginalisedcommunities and to women. With the sharp rise in health care costs, as the National Health Policy acknowledges, medical expenditure has emerged as one of the leading causes of indebtedness.



Increasing Hunger: At the same time, this has been accompanied by policies that have reduced access of the poor to employment and to public distributions systems of food so that per

Over 9000 farmers are reported to have committed suicide between 1998 and 2005! Who will take responsibility for their death?



capita availability of food has shown an alarming decrease. Thus, the per capita annual food grain absorption has declined from 178 Kg in 1991 to 154 Kg. in 2004 even as India exported food grain for animal feed in the West.

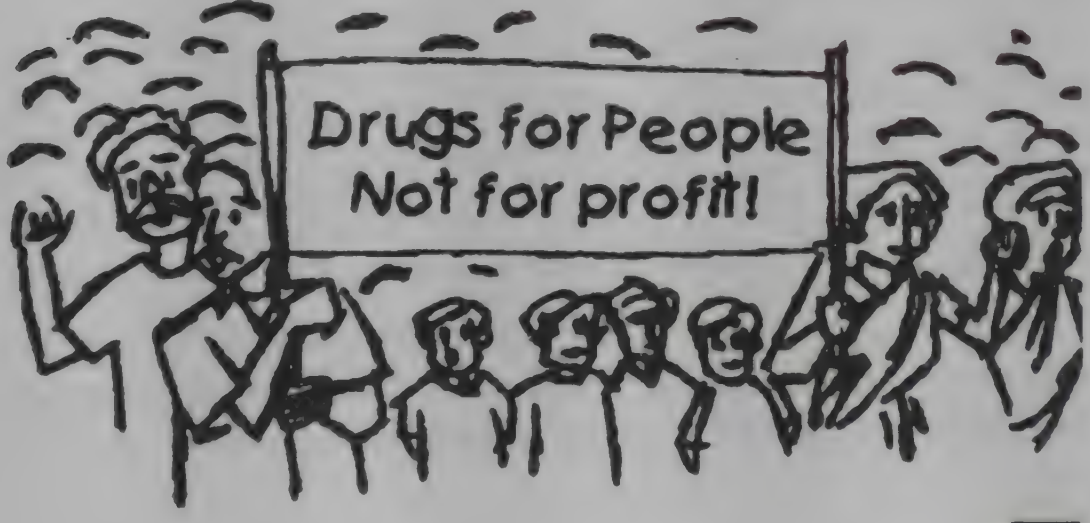
Half our rural population has food intakes below that of the countries of Sub Saharan Africa. Utilising the daily-required calorie norm of 2,400 calories, 75 per cent of the rural population could be classified as poor in 1999-2000, instead of the 27 per cent, which the Planning Commission obtains by applying an entirely illegitimate calorie norm of 1900 calories per day.

Slowing down in improvements in Child Death rates: It is thus not accidental that in addition to starvation deaths, the huge load of preventable and communicable diseases remains substantially unchanged. Infant and child mortality take an unconscionable toll of the lives of 22 lakh children every year. We are yet to achieve the National Health Policy 1983 target to reduce the Infant Mortality Rate to less than 60 per 1000 live births. More serious is the fact that the rate of decline in the Infant Mortality Rate (IMR), which was significant in the 1970s and 80s, has remarkably slowed down in the 1990s. The per centage decline in IMR between 1971-1981 was 14.7; between 1981-91 it was even more marked at 27.3 per cent. However in the period 1991-99, there has been a marked stagnation with the rate of decline in the IMR at 10 per cent. Similarly, while there has been a decline in the mortality rate of children under the age of 5 (U5MR), the pace of decline has come down and the U5MR is currently hovering around 95. During 1971-81, the per centage decline was 20.6. The decline was much

sharper during the eighties, with a per centage decline of 35.7. However during the nineties, with the onset of policies of liberalisation, the rate of decline has reduced to 15.1.

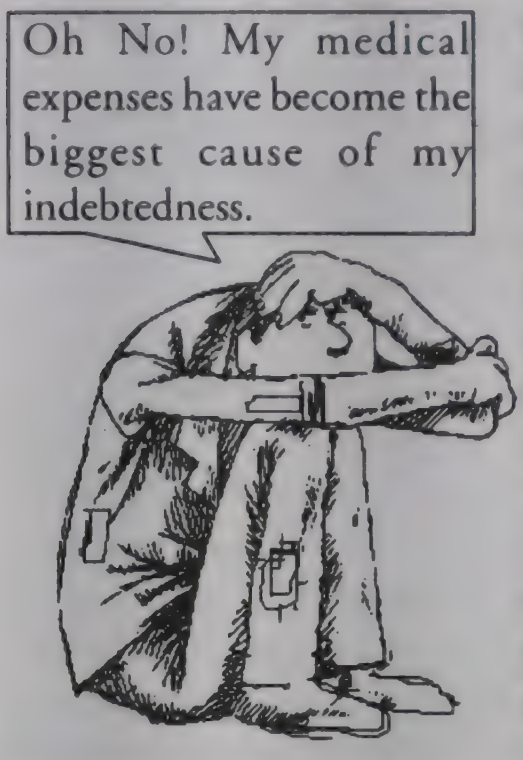
Increasing inequality: Equally significant have been other changes. Inter-regional, rural-urban, gender and economic class differentials in access to health care in India were well documented. But since the onset of liberalisation policies, these have considerably widened. The decline in public investments was matched with growing subsidies to the private sector in health care in a variety of ways. State support for private health care grew with the initiation of private-public partnerships that took a variety of forms. At the same time, there were far reaching changes in drug policies. Thus India - earlier characterised by relatively low costs of drugs and pharmaceuticals, along with a significant indigenous production of drugs - has witnessed a greater concentration of drug production, a larger role for multinationals, a higher proportion of imported drugs and unbelievably steep rises in the costs of drugs. Changes have also occurred in health care utilisation. Among people who sought outpatient services in 1995-96, more than 80 per cent did so in the private sector, a sharp increase in even the poorer states of the country. In 1995-96, 55 per cent and 57 per cent in rural and urban areas were hospitalisedin the private sector compared to 40 per cent in 1986-87.

The steep fall in rural hospitalisation rates, along with increasing use by the better off indicates that the poor are being squeezed out. "User fees" is undoubtedly one important mechanism that has



succeeded in doing this. In other words, World Bank policies on health, contained in the World Development Report, 1993 succeeded in doing exactly the opposite of what was supposed to be its main intention: reduce the utilisation of public services by the better-off to increase access to the poor.

Increasing Cost of Health Care: Costs of both outpatient and in-patient care increased sharply in both rural and urban areas, compared to the mid-eighties. Private outpatient costs increased by 142 per cent as against 77 per cent in the public sector in the rural areas. In urban areas, private outpatient costs increased by 150 per cent compared to 124 per cent in the public sector. The increase in costs in in-patient care is even more striking: average costs rose by 436 per cent in rural and 320 per cent in urban areas. It is thus not surprising that, as the National Health Policy notes, medical expenditure has emerged as one of the leading causes of indebtedness.



At the same time, the proportion of people not availing any type of medical care due to financial reasons increased between 1986-87 to 1995-96: from 10 to 21 per cent in urban areas, and from 15 to 24 per cent in rural areas.

Impact on Women's Health: More Mothers Die Each Year: 130,000 mothers die during childbirth every year. The NHP 1983 target for 2000 was to reduce Maternal Mortality Rate to less than 200 per 100,000 live births by 2000. However, 407 mothers die due to pregnancy related causes, for every 100,000 live births even today.

High, and unconscionable as these levels of maternal mortality are, it is nevertheless critical to bear in mind that they represent just a fraction of the morbidity and mortality load borne by women in the

country. Thus, for instance, deaths due to anaemia among women who are not pregnant are twice as much as among those who are. Similarly, communicable diseases take a much higher toll than that due to pregnancy and childbirth. It would be epidemiological blindness not to focus on these patterns of diseases and deaths in the quest for a politically correct reproductive health paradigm, or in designing health systems focused on women or reproduction at the cost of comprehensive primary health care. The underlying reason of course for this pattern of morbidity and mortality is not just poverty, but the fact that health systems have collapsed over the last decade and a half.

According to the National Family Health Surveys in the last decade, the MMR has increased from 424 to 540 maternal deaths per 100,000 live births.

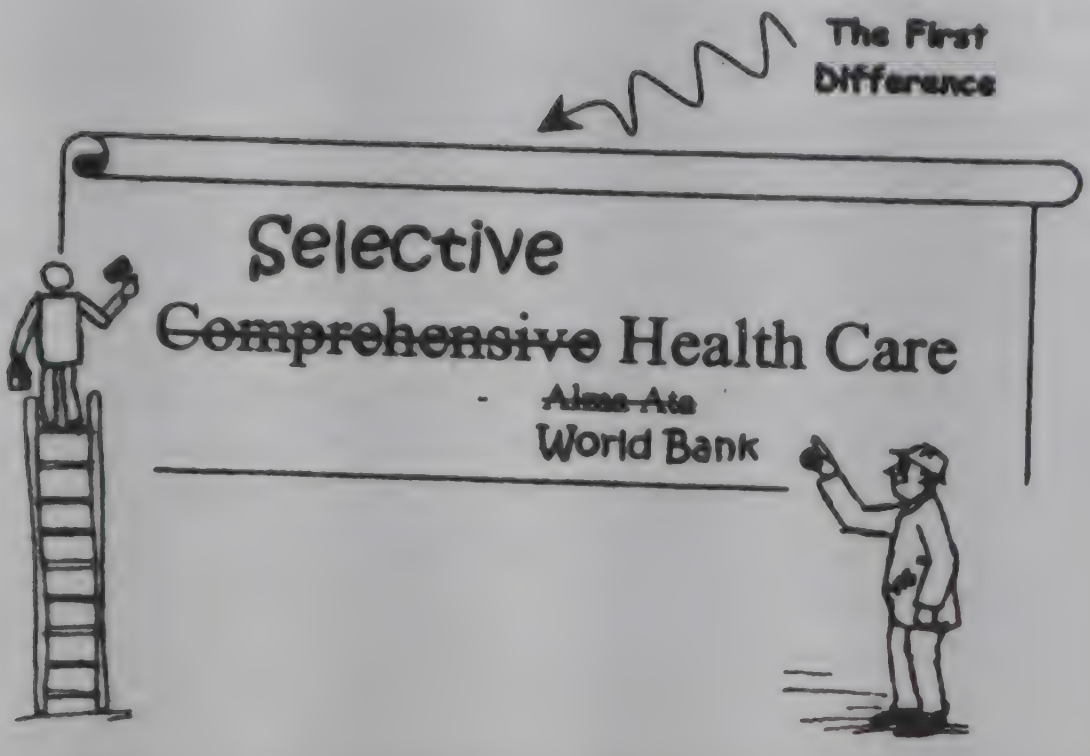
Are NGOs the answer to India's Health Care Needs?

One singular feature accompanying changes in the health sector has been its NGO-isation. This is of course not to deny that that some NGO's are doing excellent work in health and family planning, that some have served as models, that indeed a range of NGOs are involved on issues of Primary Health Care with no assistance from either the state or foreign donors. It is nevertheless important to raise the analytical issues raised by the romanticisation of all NGOs and their increasing utilisation, often at public cost, to implement schemes. What is extremely important to realise is that NGOs are a broad and mixed category in terms of ideology, activities, funding, outreach and effectiveness, and that any generalisation about them would be extremely weak, if not foolish. They are not necessarily therefore either more effective or efficient than any public funded institution and cannot be used as a substitute for a variety of reasons.

- First, NGO activities are discretionary and not mandatory. Thus they can be socially exclusive, and indeed the fear that NGO-isation may be against the interests of dalits has been frequently voiced by dalit activists and scholars.
- Second, they are not necessarily accountable, certainly not to the people they work with. Thus while a politician has the admittedly infrequent chance of being voted out for incompetence or corruption by his constituents, NGOs cannot.
- Third, the whole issue of monitoring and regulation of the private and NGO sectors is an urgent and question, but we have only to remember that the scandal of quinacrine sterilisations in the country was largely carried out by NGOs. Indeed the myth that NGOs are somehow more "representative" than political bodies has been created in the age of neo-liberalism. Thus the whole "space" for "Civil Society Organisations" in policy- making bodies that rigorously include NGOs but exclude other civil society organisations like trade unions is problematic, if not suspicious.
- Finally, it is also not true that NGOs are internally more democratic.

How was the Health Sector "Reformed" after 1991?

India embarked on its present path of economic liberalisation, on instructions from the Bank and IMF, relatively late. But in 1991 the infamous Manmohan Singh budget set things in motion. The immediate fallout was a savage cut in budgetary support to the Health sector. The cuts were severe in the first two years of the reform process, followed by some restoration in the following years. Between 1990-91 and 1993-94, there was a fall, in real terms, of expenditure on Health care both for the Centre and the states, though it was much more pronounced in the case of the states. In this period there was a compression of total developmental expenditure of state governments. Thus expenditure, in real terms, for state governments plummeted in 1991-92 and 1992-93, and just about touched the level of 1990-91 in 1993-94. This squeeze on the resources of states was



distributed in a fairly secular fashion over expenditures incurred under all developmental heads.

Health care was a major casualty, as the share of states constitutes a major portion of expenditure. A similar kind of squeeze in resource allocation was felt in all programmes, largely financed by the states, including water supply and sanitation. In contrast even in the worst "resource crunch" years, the almost exclusively centrally funded family planning programme fared much better.

Expenditure patterns on health care are grossly skewed in favour of urban areas. Expenditure cuts further distort this picture with the axe on investment falling first on rural health services. As a result of this rolling back of state support to health care the first major casualty in infrastructure development has been the rural health sector. There has been a perceptible slowing down in infrastructure creation in rural areas.

Compression of funds available with states has had a number of far reaching effects. Generally, expenditures on salaries tend to take up an inordinately large part of total expenditure. Salaries constitute 70-80% of expenditure for most major programmes, and

the trend is most distorted in the case of rural programmes, viz. rural hospitals and primary health centres. Faced with limited funds, while salaries still require to be maintained at previous levels, the burden of cutbacks are increasingly placed on supplies and materials. Ultimately a skeletal structure survives, incapable of contributing in any meaningful manner to amelioration of ill health. We are now seeing this as a major contributory factor to the disruption of the rural primary health care system. In GDP terns health expenditure in the country (already one of the lowest in the world) has declined from 1.3% in 1990 to 0.9% in 1999. While Central budgetary allocation has remained stagnant at 1.3% of total outlay, the budgetary allocation to health in state budgets (which account for over 70% of total health care expenditure of the country) has fallen in this period from 7.0% to 5.5%.8 This is a direct consequence of the squeeze imposed on the finances of the states by the economic liberalisation policies. In reaction to this, desperate state governments are queuing up in front of the World Bank to receive Bank aided projects. This is proving even more disastrous as these projects impose strict conditionalities like cost recovery.

Specifically, How do User Fees Affect the Poor?

Cost recovery is the lynchpin of the World Bank sponsored policies in India, in spite of ample evidence that such schemes, without fail, result in the exclusion of the poorest. The case for the utility of user fees uses the particularly seductive argument of equity. Seen in abstract it appears to make sense that those who can pay should, and the benefits would be shared by those who cannot. Unfortunately user fees do not work in this manner in the real world. The concept of user fees, rather, is used to legitimise the withdrawal of the state. Let us remember that the user fee argument is being forwarded in a situation where public funding of health care expenditure has fallen from 22% in the early nineties to 16% in 2000. India has one of the most privatised health systems in the world (see Table). To harp on user fees while not arguing for a quantum jump in health care expenditure by the state lets the state of the hook and shifts the basic terrain of debate on health care expenditure.

Table2
Public Sector Expenditure as Percent of Total Health Expenditure (Selected Countries)

UK	96	Canada	72	Ethiopia	36	Cameroon	20
Norway	82	Australia	72	Burkina Faso	31	Myanmar	16
Japan	80	Spain	70	Nigeria	28	**India**	**16**
Germany	78	USA	44	Pakistan	23	Cambodia	14
France	76	Cote d'Ivoire	38	Vietnam	20	Georgia	13

The concept of user fees uses the old and tested model of cross subsidisation -- some pay more to subsidise expenditure for those who pay less or nothing. This model has been used successfully in infrastructure sectors like power, telecom, air transport etc. For the model to be successful there is an assumption that a majority of users are part of the public funded system. In health care in India this is far from the case. Public facilities are utilised by those who do not have any other recourse or a powerful elite who can milk the public funded system. To expect that the latter will pay is unrealistic. As we move towards greater privatisation, those who can pay (even to a limited extent) move increasingly to the private sector. This further undermines the quality of care in the public funded system, as the relatively vocal sections have lesser stakes in its survival.

How has the Private Sector Fared in the Period of Liberalisation?

The abandonment of the Indian Government's basic duty in providing health care facilities has greatly enhanced the ability of the private sector to penetrate into the health sector. The distinction between health care and medical care is important and needs to be noted. Health care involves a lot more than just medical care, i.e. diagnosis and treatment of illnesses. Health care involves nutrition, drinking water and sanitation facilities, good housing, and a lot more. These aspects of health, for obvious reasons cannot be catered to by the private sector. But what of the medical care that is provided by

the private sector? There is a fundamental contradiction that exists in the concept of private medical care. By definition private medical care can survive only if it is profitable. What logically follows is that a private medical care provider stands to profit from ill-health - the more people fall ill and the longer they remain ill, the larger the profit for the care provider! The fundamental inconsistency can also be illustrated by the simple demand and supply logic of the market place. It can be legitimately argued that the demand for health care will always be infinite; for there is really no limit that one can set on good health. Thus, the demand for health care will always outstrip supply, and hence, under "free market" conditions, the cost of health care will always rise exponentially! We have commented earlier about the fact that developed Capitalist economies continue to pledge resources on public funded health care - to the tune of 70-80% of total health care costs. They do so, not out of any altruistic motives, but because conventional wisdom dictates that health care in the private sector is expensive and inefficient. And yet, our Government wishes to argue that privatisation of health care leads to more efficient utilisation of resources!

In spite of all the virtues of the "free-market" that are being sought to be foregrounded, the private sector is thriving because of a host of direct and indirect subsidies it receives from the Government. It is ironical that a Government, which declares that it makes poor economic sense to "subsidise" health care for the poor, provides such subsidies to the Private and Corporate Medical Sector, which cater exclusively to the needs of the rich. Thus, after providing medical education at a very nominal cost the Government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. It may be recalled that the Apollo Hospital in Delhi was built on land provided by the Delhi Government at a throwaway price! The Government also provides incentives, tax holidays, and subsidies to private pharmaceutical and medical equipment industry. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially for expensive new medical technologies. The government

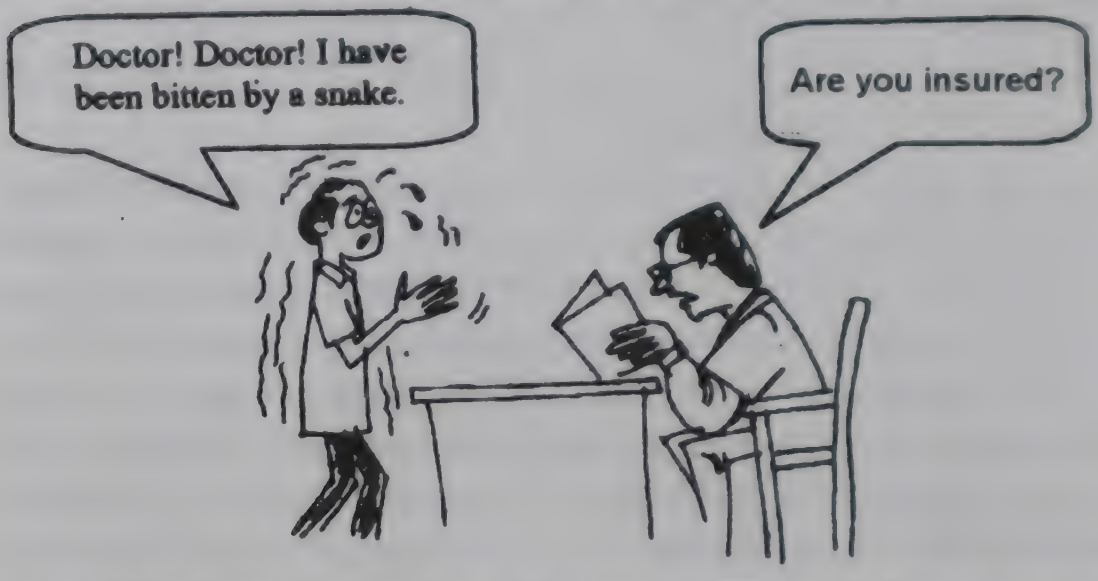
has allowed the highly profitable private hospital sector to function as trusts, which are exempt from taxes, thereby exempting them from contributing to the state exchequer even while being allowed to make huge profits. Moreover, medical and pharmaceutical research and development is largely carried out in public funded institutions but the major beneficiary is the private sector. Many private practitioners are given honorary positions in public hospitals, which they use openly to promote their personal interests.

The decade of the nineties has seen another transition taking place in the private health sector. Prior to this, the private sector consisted of a large number of individual practitioners and private hospitals and nursing homes run by medical professionals. For the first time, today, we see the entry of the organised corporate sector in medical care. As the practice of medicine becomes more technology intensive, the role of the medical professional is becoming narrower. The control of technology has thus become the key factor in determining who or which entity controls private medical care. Corporate entities, given their ability to invest in "state of the art" medical technologies, are fast wresting control of the medical care "industry". Henceforth, the return on investment made by such corporations, and not any esoteric concept of professional ethics, will determine the kind of care provided. As corporates try to maximise profits they will attempt to further push up cost of medical costs by introducing high cost technologies, and expensive diagnostic aids and medicines. This is not merely an imaginary futuristic scenario. In the United States, such an approach to medical care has lead to health care costs being the highest in the world.

Alongside the move towards reduced support to health care facilities, the government's newfound fascination with health insurance is designed to facilitate privatisation of the health sector. Wary, that a total collapse of the public health infrastructure would also affect the more vocal sections of the people - the elite and the middle class - health insurance is seen as a useful ploy to replace the Govt. health sector. But such a system addresses the needs of a small fraction, because, when the government today talks of health insurance, it

means private health insurance.

All countries with a developed health care infrastructure have health insurance, but in most the major share is made up of by Govt. supported health insurance. For example, in Japan, France, Canada, England and Netherlands the whole or majority of the population is



covered by Govt. funded health insurance. The only large country where private health insurance is dominant is the United States - a country that has the most inefficient and expensive health care system in the developed World.

What is Medical Tourism and How Does it Affect Public Health?

Globalisation has promoted a consumerist culture, thereby promoting goods and services that can feed the aspirations arising from this culture. This has had its effect in the health sector too, with the emergence of a private sector that thrives by servicing a small per centage of the population that has the ability to "buy" medical care at the rates at which the "high end" of the private medical sector provides such care. This has changed the character of the medical care sector, with the entry of the corporate sector. Corporate run institutions are seized with the necessity to maximise profits and expand their coverage. These objectives face a constraint in the form of the relatively small size of the population in developing countries that can afford services offered by such institutions. In this background, corporate

interests in the Medical Care sector are looking for opportunities that go beyond the limited domestic "market" for high cost medical care. This is the genesis of the "medical tourism" industry.

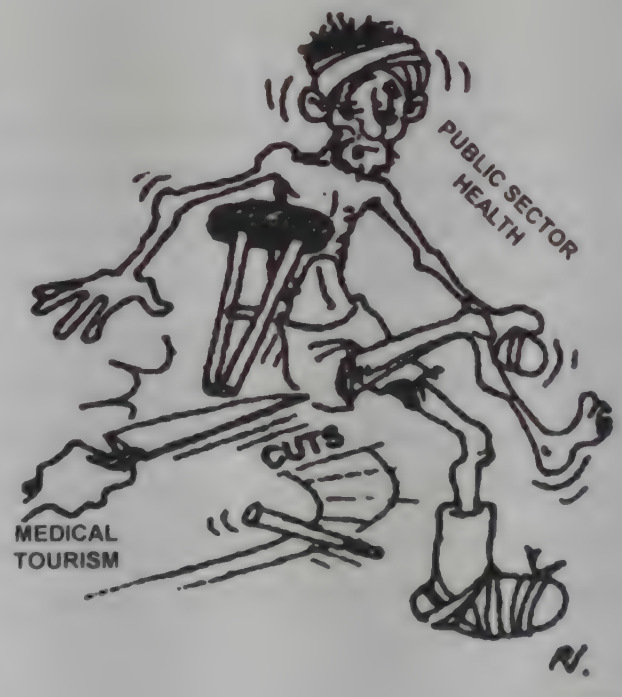
Medical Tourism as an Industry

Medical tourism is a new trend where "tourists" from a different country travel for treatment to another country where cost of treatment is lower than in the home country. Both the private medical sector and the tourist industry have a stake in promoting this trend.

In many developing countries it is being actively promoted by the Government's official policy. India's National Health policy 2002, for example, says: "To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as 'deemed exports' and will be made eligible for all fiscal incentives extended to export earnings". The formulation draws from recommendations that the corporate sector has been making in India and specifically from the "Policy Framework for Reforms in Health Care", drafted by the Prime Minister's Advisory Council on Trade and Industry, headed by Mukesh Ambani and Kumaramangalam Birla .

Growth of the Medical Tourism Industry

India has recently become a significant destination for medical tourism. According to a study by McKinsey and the Confederation of Indian Industry, medical tourism in India could become a $1 billion business by 2012. The report predicts that: "By 2012, if medical tourism were to reach 25 per cent



of revenues of private up-market players, up to Rs. 10,000 crore will be added to the revenues of these players". The Indian government predicts that India's $17-billion-a-year health-care industry could grow 13% in each of the next six years, boosted by medical tourism, which industry watchers say is growing at 30% annually.

Analysts say that as many as 2 lakh medical tourists now come to India every year. The key "selling points" of the medical tourism industry are its "cost effectiveness" and its combination with the attractions of tourism. The latter also uses the ploy of selling the "exotica" of the countries involved as well as the packaging of health care with traditional therapies and treatment methods. The slogan, being used to promote Medical Tourism is: "First World treatment' at Third World prices". The cost differential across the board is huge: only a tenth and sometimes even a sixteenth of the cost in the West. Open-heart surgery could cost up to $70,000 in Britain and up to $150,000 in the U.S.; in India's best hospitals it could cost between $3,000 and $10,000. Knee surgery (on both knees) costs 350,000 rupees ($7,700) in India; in Britain this costs £10,000 ($16,950), more than twice as much. Dental, eye and cosmetic surgeries in Western countries cost three to four times as much as in India.

Medical tourism is limited to going to large specialist hospitals run by corporate entities. It is a myth that the revenues earned by them will also finance the public sector. Evidence till date is clear that these hospitals have not honoured the conditionalities for receiving government subsidies - in terms of treatment of a certain proportion of in patients and out patients free of cost. Even today the top specialists in corporate hospitals are senior doctors drawn the public sector. Medical tourism is thus promoting an internal brain drain of health professionals into private corporate hospitals. Urban concentration of health care providers is a well-known fact - 59% of India's practitioners (73% allopathic) are located in cities, and especially metropolitan ones. Medical tourism also promotes the movement of health professionals to large urban centres, and within them, to large corporate run specialty institutions.

The argument about the potential of Medical tourism is being used already to demand for even greater concessions from the government. In countries like India, the corporate private sector has already received considerable subsidies in the form of land, reduced import duties for medical equipment etc. Medical tourism will only further legitimise their demands and put pressure on the government to subsidise them even more. Clearly, Medical tourism for a country like India - the fifth most privatised health system in the world - is a misplaced priority and amounts to subsidising the medical needs of developed countries by the use of scarce national resources.

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